



FINGER LAKES DENTAL CARE
275 PARRISH STREET
SUITE D
CANANDAIGUA, NY 14424

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

This notice describes how HEALTH INFORMATION about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION IS IMPORTANT TO US

Applicable state and federal laws require us to maintain the privacy of health information that may reveal your identity. Policies securing your identifiable health information have always been a part of this office's practice.

Federal regulation, specifically those promulgated under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) require that we give you this notice that provides you information about our privacy practices, our legal duties, and your rights concerning your health information. This notice will be posted in our office and you may request a copy at any time. This office is required to follow the privacy practices described in the Notice of Privacy Practices currently in effect. We reserve the right to change our privacy practices to the extent allowable by applicable law and to make the new provisions effective for all health information we maintain. Before we can make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you have any questions about our privacy practices, would like additional information or would like additional copies of this Notice, please contact the Office Privacy Officer.

USES AND DISCLOSURE OF HEALTH INFORMATION

Consent: We will request from you a general written consent authorizing this office to use and disclose identifiable health information about you for treatment, payment and healthcare operations. After receiving the signed consent we may use and disclose your health information for those purposes as they are defined below:

Treatment: means using and disclosing your identifiable health information to provide for, coordinate or manage your health care and related services by one or more health care providers.

Payment: means using and disclosing your identifiable health information to obtain payment for services we provide to you, confirming coverage, billing, and collection activities and utilization review.

Healthcare Operations: means using and disclosing your identifiable health information in connection with the running of our practice, including quality assessment and improvement activities, auditing functions, cost management analysis, customer service, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

In the event this office has already obtained consent from you for the use and disclosure of health information, we may continue to rely on that consent for the purposes specified.

Consent Unnecessary: our office may use and disclose your health information without your prior consent if it is “de-identified”, meaning that all references are removed that could be used to trace the information to a specific individual. In addition, your prior consent is not necessary to use or disclose protected health information in connection with treatment, payment, or healthcare operations in the following circumstances:

Emergency Treatment: In our professional judgment, should you need emergency treatment and

we cannot obtain consent prior to such treatment. We will attempt to obtain such consent, however, as soon as practicable after the delivery of such service.

Required by law: If we are required by law to treat you and we attempt to obtain such consent but are unable to do so; or

Substantial Barriers: If we are unable to obtain your consent due to substantial barriers to communicating with you, and in our professional judgment we determine that your consent to treatment is inferred from the circumstances.

Authorization: Any use or disclosure of your health other than for treatment, payment or health care operations will be made only with your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it **in writing** at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice. For certain types of health information, New York State Law requires additional notification and specific authorization with limited exceptions. In those instances, we will follow the stricter New York State law requirements.

Opportunity to Object: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, or your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical/dental supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail/answering machine messages, postcards, or letters).

YOUR RIGHTS

Access: You have the right to inspect and obtain a copy of your health information, with limited

exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable charge for copying, not to exceed \$0.75 per page, plus postage if you want the copies mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If your request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about

your health information by alternative means or to alternative locations. Your request must be made in writing and must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you feel that your privacy protections have been violated, you have the right to file a formal written complaint with us at the address listed below, or with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information:

Privacy Officer's Name: _____

Telephone: _____ Fax: _____

E-Mail: _____

Address: _____
